Changes in career plans during medical training and practice: It's time to look ahead and act

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Abstract • Résumé

Major changes in physician-resource policies and in the structuring of medical licensure requirements in the past decade have resulted in a less flexible system with respect to both choosing and changing a career path in medicine. The survey results reported by Drs. Susan Shaw, Gordon Goplen and Donald S. Houston in this issue (see pages 1035 to 1038) indicate that a high percentage of physicians now practising in Saskatchewan changed their career plans after graduation. The author argues that this finding points to the need to re-examine the transition from undergraduate to postgraduate medical education. The present system needs to be made more flexible so that medical students can gain sufficient clinical experience before deciding on an area of practice and to give practising physicians who want to change specialties the option of retraining.

Les changements majeurs des politiques relatives aux effectifs médicaux et de la structure des exigences relatives à l'octroi du permis d'exercice de la médecine au cours de la dernière décennie ont rendu le système plus rigide en ce qui a trait à la fois au choix et à la réorientation d'une carrière en médecine. Les résultats de sondage que les Drs Susan Shaw, Gordon Goplen et Donald S. Houston présentent dans ce numéro (voir pages 1035 à 1038) indiquent qu'un pourcentage élevé des médecins qui pratiquent actuellement en Saskatchewan ont changé leur choix de carrière après avoir obtenu leur diplôme. L'auteur soutient que ce résultat indique qu'il faut réexaminer le passage entre le premier cycle de la formation en médecine et le niveau postdoctoral. Il faut assouplir le système actuel afin que les étudiants en médecine acquièrent suffisamment d'expérience clinique avant de choisir un domaine de pratique et pour donner aux médecins actifs qui veulent changer de spécialité la possibilité de se recycler.

In the past decade major changes in physician-resource policies and in the structuring of medical licensure requirements have taken place in Canada. These changes include the development of a 2-year requirement for licensure by most provincial medical licensing authorities; the development of two-track licensure, initially in Quebec, and then in Alberta and Ontario; the direct intervention of the Quebec government in setting needs-based targets for postgraduate training positions, beginning in the mid-1980s; and finally, following the Barer–Stoddart report, the significant reduction of medical school admissions in all provinces. Although cutbacks in admissions may have been driven by economic factors, the changes in workforce policies also reflect an attempt by some provincial ministries of health to develop physician-resource plans. The 2-year licensure requirement was an attempt to create a level playing field for medical licensure across Canada. However, it consumed all of the "flexible" postgraduate training posts: positions were reallocated to cover the 2-year requirement and to compensate for the abrupt increase in the number of people entering specialty programs immediately after obtaining their medical degree.[1] A less flexible system resulted, not because of a decrease in the number of training posts, as is commonly perceived, but because of the shift of existing posts to cover the new demands.

Surprisingly few attempts have been made to assess formally the impact of these significant new developments on the evolution of trainees' careers or to re-examine the relationship between undergraduate and

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postgraduate medical education. Although there has been a good deal of informal discussion, it could be argued that responses to the new policies have been reactive rather than proactive. For example, those who have focused on the loss of rotating internships have expressed a wish to return to the past. However, even if the appropriate medical agencies, burdened with other major challenges, were in a position to address the consequences of these changes, data on which to plan solutions are lacking or, at best, badly dated by the rapid evolution of new policies. Testimonials attract attention to the problem but do not provide a valid basis for solutions. Population-based data are needed for that.

Against this background the article by Drs. Susan Shaw, Gordon Goplen and Donald S. Houston (see pages 1035 to 1038 of this issue) is a welcome addition to the literature on physician career planning in Canada. In their survey of the active membership of the Saskatchewan Medical Association they sought to identify the career plans that Saskatchewan practitioners had made in their next-to-last year of medical school, what their probable career choice would have been if they had been forced to decide at that time, and the number of practising physicians who had changed their career path after graduation from medical school. Shaw and associates found that 57.8% of the respondents were practising in a field other than the one they had planned on in their next-to-last year of medical school, 63.1% were practising in a field other than the one they would have chosen at that time and 42.9% had changed their field of training or practice since graduation.

The study is not without faults. For example, the response rate was lower than one might have hoped for; perhaps the use of a population sample with more vigorous follow-up would have been preferable. The lack of a pretest was also unfortunate because, as the authors note, some refinement of the questionnaire would have elicited more helpful data. Obviously, the survey suffers from being historical in its view: memory can be selective. Then there is the question of the geographic area selected: Saskatchewan is one of two or three provinces with a very high proportion of physicians educated outside of Canada. Further analysis by Shaw and associates showed that although the general trend indicated by their results held true, graduates of the University of Saskatchewan were less likely to change their career path after graduation than were graduates of schools in other provinces or outside of Canada.

None the less, there is no reason to doubt the general conclusions drawn by Shaw and associates. If we assume that their data accurately reflect the study group's thoughts during their next-to-last year of medical school, career changes appear to have been common among the respondents and to have occurred predominantly after graduation. These results are consistent with data from the Canadian Resident Matching Service (CaRMS) Post-Match Survey for 1995,[2] which showed that although the percentage had fallen, 40% of graduating medical students still felt poorly to moderately prepared to make their residency choice. (The other 60% felt well prepared.)

Possible solutions

Shaw and associates' findings show that a change in career path after graduation was a reality for the majority of physicians now practising in Saskatchewan. In light of the CaRMS survey data, career changes still appear to be a concern for many senior students in Canadian medical schools today, despite the current efforts of the faculties to assist and support them through this process. It may be that the rotating internship provided a safety valve for many graduates, whether they were undecided about their specialty, wanted to change specialty after more clinical experience or needed to spend a year or two in practice because of debt load or other financial constraints. Leaving aside the important issue of financial imperatives, other reasons for career changes can and should be addressed with a view to feasible solutions. What are some of the possibilities?

- If the problem of career change is as prevalent as Shaw and associates suggest, could it be an artifact of the two solitudes of undergraduate and postgraduate programs? It seems that the disjunction between the general nature of undergraduate education and the specific nature of postgraduate education is such that many students are not prepared to make career choices. Is it possible that much of this difficulty stems from a lack of first-hand clinical experience in various specialties (including family medicine) before the residency match and that for many years the rotating internship served as a transition between undergraduate education and the real career choice? This would imply that in the past at many medical schools the rotating internship encouraged a *laissez-faire* approach to the problem of the undergraduate–postgraduate disjunction. Although schools have worked hard to adapt their medical degree programs to accommodate the new system, the CaRMS data suggest that more needs to be done. Can schools reassess yet again the timing and sequence of clerkship experiences and identify additional ways to prepare students to make choices? One hopes that the answer is Yes.
- Because Shaw and associates' data suggest that career choices may be especially problematic for students in or applying to Royal College programs, should the preparation of these students be re-examined?

Should a more integrated view be taken to clerkship and postgraduate year 1, perhaps by having a 1-year transition period spanning the last 6 months of clerkship and the first 6 months of postgraduate year 1? Undergraduate and postgraduate directors would need to work together closely and to seek the input of certifying bodies. However, problems such as how to integrate this approach with residency matching plans and students' need to "lock in" postgraduate experience at their school of graduation would make this integrated approach unwieldy.

- A variation on the latter strategy existed for many years at Dalhousie University, where students had to complete a rotating internship (a fifth year) before graduation. Extensive community experience was part of this exercise. Would it be feasible to offer an optional year of rotating clinical experience before graduation in return for a commitment to undertake a period of community practice after residency? For example, those who could not decide on a specialty could undertake an optional fifth year of medical school, with a subsequent compulsory period of community practice or other service. Unfortunately, the idea of an optional fifth year (or fourth year, in the case of 3-year programs) is not likely to be well received by provincial governments in an era of budget cuts, even if cash-strapped deans were to find it tempting.
- The use of training cards would help to some degree by offering the student an entitlement to training through to completion provided that choices were made within provincial and regional training guidelines. This would avoid the situation of trainees having to compete for positions each year. It would also allow for changes in career choice after graduation and for remedial rotations in selected cases, but a separate complement of designated re-entry positions for those currently in practice would be needed. However, the training card and variations thereof have often been rejected outside of Quebec, particularly in the west.
- If solutions such as obtaining clinical experience at an earlier stage of undergraduate clerkship are not immediately forthcoming or require time to be implemented, the question of how to provide retraining opportunities for practising physicians who wish to retrain must be addressed immediately by all parties. For example, those seeking re-entry to postgraduate education could be retrained to meet specific community needs or to take on new academic challenges in the recently created community-based medical education programs, where earlier community experience is a distinct advantage. This would also offer the possibility of change for those who have made a bad choice in today's less flexible system and are faced with the awful fear of being trapped forever. To date this approach has been a focal point in the policy recommendations of the National Coordinating Committee on Postgraduate Medical Training.[3] Composed of representatives of the key stakeholders in Canadian medicine and medical education and of representatives of the provincial ministries of health, the committee requested such a provision in their sixth report to the Conference of Deputy Ministers of Health.[3] Unfortunately, it appears that most provinces, even if they agree in principle with the concept of re-entry, are not able to make the necessary fiscal commitment.

From this review of options, there appears to be at least one workable solution to the problem of forcing career decisions on young people before they have had an opportunity to obtain first-hand clerkship experience of a given specialty. I refer to the first option discussed above. Is there any evidence that this or any of the other potential solutions can work? What can be learned, for instance, from Quebec's longer experience with the current system? It has been suggested that medical students in Quebec had fewer problems initially with the 2-year licensure system and with constraints on positions because the training card and the existence of a re-entry (*retour de pratique*) option offered some flexibility. However, the problem of deadlines for career decisions during clerkship is not an issue in Quebec because a low percentage of francophone students enter the CaRMS match. But for Quebec clerks who do enter the match, it appears that faculty members spend more time counselling them. At McGill University, for example, alterations to the clerkship rotations were made to better prepare senior students for career decisions before the match deadlines.

Psychological hurdles

Whatever the merits of the various solutions, two longstanding psychological hurdles must be overcome. The first is the assumption that career changes of the magnitude suggested by Shaw and associates' study are simply human nature. If one accepts this view, one must also accept the conclusion that most young physicians cannot make a reliable choice of career and that there is no remedy for a situation in which 40% to 60% of medical students and practitioners make career changes. The second is the *laissez-faire* approach to career choice that evolved with respect to undecided students. With the introduction in the 1970s of straight internships, clinical clerkships and residencies for all disciplines, the period during which students could decide about postgraduate education was greatly compressed. Many solved the

problem by viewing the rotating internship as a transitional year in which to make a decision; this was not its original function. In reality, the value of an extra year in which to decide on a specialty program may have been overestimated, given that choices about residency positions had to be made after only one or, at most, two internship rotations. More critical is the fact that a *laissez-faire* approach is no longer tenable in the present economic environment. The longer we avoid dealing with the problem of the transition from undergraduate to postgraduate education, the more the problem of career choice will fester. If educators and students could overcome these psychological hurdles, they would be able to move forward in a proactive way to consider necessary and innovative improvements to the career selection process.

The need for flexibility

Finally, let us return to the related issues of the loss of flexibility in the system and the need for re-entry positions. As I have noted, although the need for such positions is accepted, finding the necessary funding appears to be a problem. But there is some hope. When cutbacks in medical school admissions lead to a reduced demand for postgraduate positions in 1997, a window of opportunity will open for the reallocation of postgraduate positions as re-entry positions. This opportunity is fast approaching; we must take action *now*. It is essential that all representatives of the profession aggressively pursue the matter of re-entry positions with key officials without delay.

References

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